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BREAST AND CERVICAL CANCER TREATMENT

REGULAR POLICY CHANGE NUMBER:	2
IMPLEMENTATION DATE:	1/2002
ANALYST:	Cheri Johnson
FISCAL REFERENCE NUMBER:	3

	FY 2005-06	FY 2006-07
FULL YEAR COST - TOTAL FUNDS	$79,403,000	$77,895,000
- STATE FUNDS	$32,201,300	$33,003,950
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$79,403,000	$77,895,000
STATE FUNDS	$32,201,300	$33,003,950
FEDERAL FUNDS	$47,201,700	$44,891,050

DESCRIPTION

The Budget Act of 2001 (Ch. 106/2001) authorized the Breast and Cervical Cancer Treatment Program (BCCTP) effective January 1, 2002, for women under 200% of the FPL.

Enhanced Title XIX Medicaid funds (65%FFP/35%GF) may be claimed under the federal Medicaid Breast and Cervical Cancer Treatment Act of 2000 (P.L. 106-354) for cancer treatment and full scope Medi-Cal benefits for women under age 65 who are citizens or legal immigrants with no other health coverage.

A State-Only program covers women aged 65 or older, women with inadequate health coverage, undocumented women, and males for cancer treatment only. The coverage term is 18 months for breast cancer and 2 years for cervical cancer. Estimated State-Only costs include undocumented persons' nonemergency services during cancer treatment.

Beneficiaries are screened through Centers for Disease Control (CDC) and Family PACT providers.

Assumptions:

1. There were 9,471 fee-for-service (FFS) eligibles and 1,369 managed care eligibles as of March 2006 (total of 10,840). 2,393 of the FFS eligibles were eligible for State-Only services (Aid Codes 0R, 0T, 0U and 0V).

2. 3,387 of the FFS eligibles were in Accelerated Enrollment Aid Code 0N as of March 2006.

3. 245 of the FFS eligibles were in State-Only Other Health Coverage Aid Code 0R as of March 2006. Assume the State will pay Medicare and other health coverage premiums for an average of 240 0R beneficiaries monthly in FY 2005-06 and 275 OR beneficiaries monthly in FY 2006-07. Assume an average monthly premium cost per beneficiary of $200.

   FY 2005-06: 240 x $200 x 12 months = $576,000 ($576,000 GF)
   FY 2006-07: 275 x $200 x 12 months = $660,000 ($660,000 GF)

BREAST AND CERVICAL CANCER TREATMENT

REGULAR POLICY CHANGE NUMBER: 2

4. The Budget Act of 2006 adopted by the Legislature reduced funding by $6,000,000 ($2,000,000 GF) in FY 2006-07 to reflect approval of additional staff to process a backlog of redeterminations.

5. FFS costs are estimated as follows:

	FY 2005-06		FY 2006-07	
	TF	GF	TF	GF
Full-Scope Costs	$72,618,000	$25,416,000	$75,217,000	$26,326,000
State-Only Costs	$6,785,000	$6,785,000	$8,678,000	$8,678,000
Services	$6,209,000	$6,209,000	$8,018,000	$8,018,000
Premiums	$576,000	$576,000	$660,000	$660,000
Legislative Reduction	$0	$0	($6,000,000)	($2,000,000)
Total	**$79,403,000**	**$32,201,000**	**$77,895,000**	**$33,004,000**

6. All BCCTP costs are budgeted in policy changes. BCCTP managed care costs are budgeted in managed care policy changes.

7. Federal reimbursement for State-Only BCCTP based on the certification of public expenditures is budgeted in Policy Change 101, Hosp. Financing - BCCTP, in the Policy Changes section of the estimate.

MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA

REGULAR POLICY CHANGE NUMBER: 16
IMPLEMENTATION DATE: 7/1984
ANALYST: Shelley Stankeivicz
FISCAL REFERENCE NUMBER: 28

	FY 2005-06	FY 2006-07
FULL YEAR COST - TOTAL FUNDS	$44,515,000	$47,515,000
- STATE FUNDS	$22,257,500	$22,258,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$44,515,000	$47,515,000
STATE FUNDS	$22,257,500	$22,258,000
FEDERAL FUNDS	$22,257,500	$25,257,000

DESCRIPTION

The Multipurpose Senior Services Program is designed to evaluate the effects of providing a comprehensive array of social and health services to persons 65 or older who are "at risk" of long-term care. The program provides services under a federal home and community-based services waiver to an average of 16,335 clients in 11,789 client slots, at $3,776 per year per client slot.

CDHS pays the MSSP claims, and prior to FY 2006-07, both the GF and FFP were budgeted in the CDHS budget. The Budget Act of 2006 enacted by the Legislature removes the GF ($22,258,000) from the CDHS budget and includes it in the CDA budget beginning with FY 2006-07. The Budget Act also increases the CDHS reimbursement authority by $22,258,000 so that the CDA GF can be transferred back to CDHS as a reimbursement at the beginning of the fiscal year and CDHS can pay the MSSP claims.

In addition, the Budget Act of 2006 enacted by the Legislature increased the total funding for the MSSP program by $6,000,000. The $3,000,000 in FFP was added to the CDHS budget; however, CDHS's reimbursement authority was inadvertently not increased for the additional $3,000,000 in CDA GF that will be transferred to CDHS. This correction in the reimbursement amount will be made in the November 2006 Estimate.

(Dollars in Thousands)

	FY 2005-06			FY 2006-07		
	TF	DHS-GF	FFP	TF	Reimb. from CDA	FFP
MSSP	**$44,515**	**$22,257.5**	**$22,257.5**	**$47,515**	**$22,258**	**$25,257**

ADULT DAY HEALTH CARE REFORMS

REGULAR POLICY CHANGE NUMBER: 25
IMPLEMENTATION DATE: 3/2007
ANALYST: Shelley Stankeivicz
FISCAL REFERENCE NUMBER: 1074

	FY 2005-06	FY 2006-07
FULL YEAR COST - TOTAL FUNDS	$0	$862,000
- STATE FUNDS	$0	$431,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$862,000
STATE FUNDS	$0	$431,000
FEDERAL FUNDS	$0	$431,000

DESCRIPTION

The current reimbursement rate for Adult Day Health Care (ADHC) is 90% of the nursing facility-level A rate. This is a bundled, all-inclusive rate for all ADHC services which was set by a court settlement in 1993. The Governor's May Revision included a proposal to revise the way ADHCs are paid by:

1. Unbundling the rate into its component services, and retaining the cap of 90% of the NF-A rate. Only the remaining bundled procedure code that includes overhead and unskilled services would require prior authorization, and ADHCs would "bill direct" for ancillary and skilled services.

2. Tightening medical criteria.

3. Having CDA perform post-payment audits of participant charts to ensure services billed were actually provided and medically necessary.

4. Adding Medi-Cal field office staff to do on-site approvals of requests for prior authorization, to allow review of patients' records.

The Budget Act of 2006 enacted by the Legislature eliminated the expected savings for FY 2006-07. However, funding was inadvertently restored at the November Estimate level of $19,819,000 ($9,910,000 GF) rather than at the May Estimate level of $18,957,000 ($9,478,500 GF). Therefore, this policy change reflects the $862,000 ($431,000 GF) in excess funding provided by the Legislature.

(Dollars in thousands)	**FY 2006-07**	
	$862 TF	**$431 GF**

CAPITATION RATE INCREASES

REGULAR POLICY CHANGE NUMBER: 150
IMPLEMENTATION DATE: 7/2006
ANALYST: Shelley Stankeivicz
FISCAL REFERENCE NUMBER: 1118

	FY 2005-06	FY 2006-07
FULL YEAR COST - TOTAL FUNDS	$0	$78,050,000
- STATE FUNDS	$0	$39,025,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$78,050,000
STATE FUNDS	$0	$39,025,500
FEDERAL FUNDS	$0	$39,024,500

DESCRIPTION

The Department recently conducted a financial review of all Medi-Cal managed care plans to determine if any additional rate adjustments were needed to ensure that all plans would have sufficient resources to provide quality care to Medi-Cal beneficiaries. In April, 2006, six managed care contractors were determined to be in need of a rate increase to minimize the risk of insolvency and maintain compliance with required financial standards. The total cost of the rate increase for each plan was determined based on each plan's required minimum Tangible Net Equity (TNE). The rate increases will be implemented during FY 2006-07. Each individual plan's increase will begin at the start of that plan's new rate period, as follows:

Plan	Rate Period Begins
Central Coast Alliance for Health (COHS)	January 1, 2007
Health Plan of San Mateo (COHS)	July 1, 2006
Partnership Health Plan (COHS)	July 1, 2006
Santa Barbara Health Authority (COHS)	January 1, 2007
Contra Costa Health Plan (Two-Plan Model)	October 1, 2006
Community Health Group (Geographic Managed Care)	July 1, 2006

The total amount of the increase for each plan in FY 2006-07 was adjusted to reflect the funding provided to the plans with the provider rate restoration. Thus, the total increase for each plan was reduced by six months (January - June 2007) of the provider rate increase applicable to the plan.

CAPITATION RATE INCREASES

REGULAR POLICY CHANGE NUMBER: 150

FY 2006-07

Plan	**Total Funds**	**General Fund**
Central Coast Alliance for Health	$17,370,000	$8,685,500
Health Plan of San Mateo	$7,670,000	$3,835,000
Partnership Health Plan	$25,300,000	$12,650,000
Santa Barbara Health Authority	$11,160,000	$5,580,000
Contra Costa Health Plan	$2,860,000	$1,430,000
Community Health Group	$13,690,000	$6,845,000
Total	**$78,050,000**	**$39,025,500**

The figures above include a technical correction of $16,875,000 ($8,438,000 GF) for Central Coast, Santa Barbara and San Mateo that was added to the Budget Act of 2006, adopted by the Legislature.

ELIMINATION OF PODIATRY TARS

REGULAR POLICY CHANGE NUMBER:	152
IMPLEMENTATION DATE:	7/2006
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1122

	FY 2005-06	FY 2006-07
FULL YEAR COST - TOTAL FUNDS	$0	$200,000
- STATE FUNDS	$0	$100,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$200,000
STATE FUNDS	$0	$100,000
FEDERAL FUNDS	$0	$100,000

DESCRIPTION

The Health Budget Trailer Bill of 2006 amended the Welfare and Institutions Code to remove certain podiatry services from prior authorization. Prior to implementation of this legislation, podiatric office visits were covered as medically necessary and all other outpatient and inpatient podiatry services were subject to prior authorization and limited to medical and surgical services necessary to treat disorders of the feet, ankles, or tendons that insert into the foot, secondary to or complicating chronic medical diseases, or which significantly impair the ability to walk.

The Health Budget Trailer Bill provides that prior authorization for podiatric services on an outpatient basis will not be required if:

1. The services are provided by a doctor of podiatric medicine acting within the scope of his or her practice;
2. The services are related to trauma, infection management, pain control, wound management, diabetic foot care, or limb salvage;
3. The services are medically necessary;
4. An urgent or emergency need for the services exists;
5. The patient was referred to the podiatrist by a physician, and
6. Prior authorization is not required for a physician providing the same service.

The Budget Act of 2006, as enacted by the Legislature, added $200,000 ($100,000 GF) to fund this change, effective July 1, 2006.

FY 2006-07	FF	$100,000
	GF	$100,000
	Total	$200,000

DME REIMBURSEMENT CHANGES

REGULAR POLICY CHANGE NUMBER: 153
IMPLEMENTATION DATE: 7/2006
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 1123

	FY 2005-06	FY 2006-07
FULL YEAR COST - TOTAL FUNDS	$0	$4,471,000
- STATE FUNDS	$0	$2,235,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$4,471,000
STATE FUNDS	$0	$2,235,000
FEDERAL FUNDS	$0	$2,236,000

DESCRIPTION

The Health Budget Trailer Bill of 2006 made the following changes to the reimbursement methodology for certain durable medical equipment (DME) items (custom wheelchairs, custom rehabilitation equipment, and oxygen):

1. For DME with no specified maximum rate, it adds the option of paying the manufacturer's suggested retail price on June 1, 2006, documented by a printed catalog or hard copy of an electronic catalog page showing the price on that date, reduced by a percentage discount not to exceed 20%;

2. For custom wheelchairs and accessories, it adds the option of paying the manufacturer's suggested retail price on June 1, 2006, documented by a printed catalog or hard copy of an electronic catalog page showing the price on that date, reduced by a percentage discount not to exceed 15%, if the provider employs or contracts with a qualified rehabilitation professional;

3. For oxygen delivery systems and contents, it utilizes national Healthcare Common Procedure Coding System (HCPCS) codes to establish reimbursement which will be the lesser of (a) the amount billed as specified in Section 51008.1 of Title 22 of the California Code of Regulations, (b) an amount not to exceed 80% of the Medicare rate, or (c) the guaranteed acquisition cost negotiated by contract, plus a percentage markup established by the Department.

Changes 1 and 2 are effective upon passage of the Health Trailer Bill. Change 3 is effective January 1, 2007.

The Budget Act of 2006, as enacted by the Legislature, included funding of $4,471,000 ($2,235,000 GF) for these changes.

PACE RATES AT 90% OF UPL

REGULAR POLICY CHANGE NUMBER:	154
IMPLEMENTATION DATE:	7/2006
ANALYST:	Shelley Stankeivicz
FISCAL REFERENCE NUMBER:	1124

	FY 2005-06	FY 2006-07
FULL YEAR COST - TOTAL FUNDS	$0	$2,206,000
- STATE FUNDS	$0	$1,103,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$2,206,000
STATE FUNDS	$0	$1,103,000
FEDERAL FUNDS	$0	$1,103,000

DESCRIPTION

The Health Budget Trailer Bill of 2006 requires the Department to establish capitation rates for PACE plans at no less than 90% of the fee-for-service equivalent cost, including the Department's cost of administration. The Budget Act of 2006, as enacted by the Legislature, includes $2,206,000 ($1,103,000 GF) to fund the increase.

Rates will be set at the current rate, or 90% of UPL, whichever is greater, effective July 1, 2006.